

		FOR OHF USE					

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2003  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2003)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0035642</u></p> <p><b>Facility Name:</b> <u>NEW BEGINNINGS CARE CENTRE</u></p> <p><b>Address:</b> <u>1000 DIXON AVENUE</u> <u>ROCKFALLS</u> <u>61071</u> Number City Zip Code</p> <p><b>County:</b> <u>WHITESIDE</u></p> <p><b>Telephone Number:</b> <u>( 815 ) 625-8510</u> <b>Fax #</b> <u>( 815 ) 625-8443</u></p> <p><b>IDPA ID Number:</b> <u>36-3651790</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>07/01/89</u></p> <p><b>Type of Ownership:</b></p> <table><tr><td><input type="checkbox"/></td><td><b>VOLUNTARY,NON-PROFIT</b></td><td><input checked="" type="checkbox"/></td><td><b>PROPRIETARY</b></td><td><input type="checkbox"/></td><td><b>GOVERNMENTAL</b></td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td><b>IRS Exemption Code</b> _____</td><td></td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other _____</td></tr><tr><td></td><td></td><td><input checked="" type="checkbox"/></td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Other _____</td><td></td><td></td></tr></table> <p><b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <u>( 847 ) 675-3585</u></p>	<input type="checkbox"/>	<b>VOLUNTARY,NON-PROFIT</b>	<input checked="" type="checkbox"/>	<b>PROPRIETARY</b>	<input type="checkbox"/>	<b>GOVERNMENTAL</b>	<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County	<b>IRS Exemption Code</b> _____		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other _____			<input checked="" type="checkbox"/>	"Sub-S" Corp.					<input type="checkbox"/>	Limited Liability Co.					<input type="checkbox"/>	Trust					<input type="checkbox"/>	Other _____			<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table><tr><td rowspan="3"><b>Officer or Administrator of Provider</b></td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>ROBERT HEDGES</u> (Date) _____</td></tr><tr><td>(Title) <u>PRESIDENT</u></td></tr><tr><td rowspan="5"><b>Paid Preparer</b></td><td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td></tr><tr><td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td></tr><tr><td>(Firm Name &amp; Address) <u>KRUPNICK BOKOR KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u></td></tr><tr><td>(Telephone) <u>( 847 ) 675-3585</u> <b>Fax #</b> <u>( 847 ) 675-5777</u></td></tr><tr><td><b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630</td></tr></table>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>ROBERT HEDGES</u> (Date) _____	(Title) <u>PRESIDENT</u>	<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>( 847 ) 675-3585</u> <b>Fax #</b> <u>( 847 ) 675-5777</u>	<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630
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Facility Name & ID Number NEW BEGINNINGS CARE CENTRE

# 0035642 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>55</u>	Skilled (SNF)	<u>55</u>	<u>20,075</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>55</u>	TOTALS	<u>55</u>	<u>20,075</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,501</u>	<u>1,501</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	<u>12,342</u>	<u>796</u>		<u>13,138</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,342</u>	<u>796</u>	<u>1,501</u>	<u>14,639</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.92%

D. How many bed-hold days during this year were paid by Public Aid? \_\_\_\_\_ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 07/01/89

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 07/01/89 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number of beds certified 55 and days of care provided 1,501

Medicare Intermediary ADMINISTAR FED

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **NEW BEGINNINGS CARE CENTRE** # **0035642** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	104,051	4,417	4,081	112,549		112,549		112,549			1
2	Food Purchase		61,486		61,486	(2,446)	59,040	(109)	58,931			2
3	Housekeeping	33,449	6,470		39,919		39,919		39,919			3
4	Laundry	28,940	3,918	810	33,668		33,668		33,668			4
5	Heat and Other Utilities			52,312	52,312		52,312	376	52,688			5
6	Maintenance	21,930	4,899	17,714	44,543		44,543	4,273	48,816			6
7	Other (specify):*			2,256	2,256		2,256	18	2,274			7
8	<b>TOTAL General Services</b>	188,370	81,190	77,173	346,733	(2,446)	344,287	4,558	348,845			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			3,850	3,850		3,850		3,850			9
10	Nursing and Medical Records	541,480	67,233	22,464	631,177	(91,171)	540,006	727	540,733			10
10a	Therapy	19,369	55	41,974	61,398		61,398		61,398			10a
11	Activities	36,289	374		36,663		36,663		36,663			11
12	Social Services			2,020	2,020		2,020		2,020			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* <b>CHAPLAIN</b>	9,151			9,151		9,151		9,151			15
16	<b>TOTAL Health Care and Programs</b>	606,289	67,662	70,308	744,259	(91,171)	653,088	727	653,815			16
	<b>C. General Administration</b>											
17	Administrative	50,286		892	51,178		51,178	15,904	67,082			17
18	Directors Fees											18
19	Professional Services			53,625	53,625		53,625	(6,151)	47,474			19
20	Dues, Fees, Subscriptions & Promotions			7,421	7,421		7,421	(4,705)	2,716			20
21	Clerical & General Office Expenses	20,922	5,195	9,348	35,465		35,465	15,421	50,886			21
22	Employee Benefits & Payroll Taxes			127,395	127,395	2,446	129,841		129,841			22
23	Inservice Training & Education							41	41			23
24	Travel and Seminar			747	747		747	1,590	2,337			24
25	Other Admin. Staff Transportation			1,676	1,676		1,676		1,676			25
26	Insurance-Prop.Liab.Malpractice			44,844	44,844		44,844	549	45,393			26
27	Other (specify):*							8,578	8,578			27
28	<b>TOTAL General Administration</b>	71,208	5,195	245,948	322,351	2,446	324,797	31,227	356,024			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	865,867	154,047	393,429	1,413,343	(91,171)	1,322,172	36,512	1,358,684			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	<b>DIETARY</b>		
	DIETITIAN CONSULTANT XVIII B 35-2	4,081	
	REPAIRS & MAINTENANCE	0	
		0	4,081
3	<b>HOUSEKEEPING</b>		
		0	
		0	0
4	<b>LAUNDRY</b>		
	EQUIPMENT REPAIRS & MAINTENANCE	810	
		0	810
5	<b>HEAT &amp; OTHER UTILITIES</b>		
	GAS HEAT	20,290	
	ELECTRICITY	16,556	
	WATER	13,871	
	CABLE TV - LOBBY	1,595	
		0	52,312
6	<b>MAINTENANCE</b>		
	GROUNDS MAINTENANCE	2,169	
	PAINTING & DECORATING	861	
	BUILDING REPAIRS	7,487	
	MAINTENANCE TRAVEL	0	
	EQUIPMENT MAINTENANCE & REPAIR	4,541	
	ELEVATOR MAINTENANCE & REPAIR	0	
	OUTSIDE LABOR	0	
	EXTERMINATING SERVICE	855	
	FIRE SERVICE	1,801	
		0	
		0	
		0	17,714
7	<b>OTHER</b>		
	SCAVENGER	2,256	
	SECURITY SERVICE	0	2,256
9	<b>MEDICAL DIRECTOR</b>		
	MEDICAL DIRECTOR FEES XVIII B 36-2	3,850	3,850

LINE		SCHED REF	TOTAL
10	<b>NURSING</b>		
	CONTRACT NURSING XVIII C 53-2	18,413	
	LABORATORY & XRAY EXPENSE	3,451	
	PURCHASED SERVICES	0	
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0	
	PHARMACY CONSULTANT XVIII B 39-2	600	
	UTILIZATION REVIEW FEES XVIII B __-2	0	
	PHYSICIANS XVIII B __-2	0	
	PSYCHIATRIC XVIII B __-2	0	
	RN CONSULTANT XVIII B 38-2	0	
		0	
		0	22,464
10a	<b>THERAPY</b>		
	PHYSICAL THERAPY SERVICES	26,883	
	SPEECH THERAPY SERVICES	647	
	OCCUPATIONAL THERAPY SERVICES	11,333	
	REHABILITATION CONSULTANT XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	1,661	
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	1,450	
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0	
	<b>SPEECH THERAPY CONSULTANT XVIII B 43-2</b>	0	41,974
11	<b>ACTIVITIES</b>		
	CABLE TV - PATIENT ROOMS	0	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0	
		0	0
12	<b>SOCIAL SERVICES</b>		
	SOCIAL REHABILITATION SERVICES	330	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0	
	SOCIAL WORKER XVIII B 45-2	1,690	
		0	2,020
13	<b>NURSE AIDE TRAINING</b>		
	NURSE AIDE TRAINING COSTS XIII	0	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 892	892
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 13,308	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 40,317	
		0	53,625
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 4,492	
	EMPLOYEE WANT ADS	XIX F 1,100	
	CONTRIBUTIONS	VI 20 XIX F 0	
	DUES & SUBSCRIPTIONS	XIX F 61	
	LICENSES & PERMITS	XIX F 604	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 302	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 862	7,421
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	531	
	EQUIPMENT REPAIR & MAINTENANCE	489	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 745	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	7,583	
	MESSENGER SERVICE	0	
		0	9,348

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 66,239	
	UNEMPLOYMENT COMPENSATION	XIX D 17,621	
	WORKERS COMPENSATION INSURANCE	XIX D 28,256	
	HOSPITALIZATION INSURANCE	XIX D 10,113	
	EMPLOYEE BENEFITS - OTHER	XIX D 5,166	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	127,395
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	0	0
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 747	
	TRAVEL	XIX G 0	
		0	
		0	747
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	1,676	1,676
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	44,844	44,844
27	OTHER		
	BAD DEBTS	VI 24 0	
		0	0

GRAND TOTAL COLUMN 3 OTHER

393,429

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			18,698	18,698		18,698	25,796	44,494			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,625	15,625		15,625	87,840	103,465			32
33	Real Estate Taxes			14,997	14,997		14,997		14,997			33
34	Rent-Facility & Grounds			122,012	122,012		122,012	(122,012)				34
35	Rent-Equipment & Vehicles			5,227	5,227		5,227		5,227			35
36	Other (specify):*											36
37	TOTAL Ownership			176,559	176,559		176,559	(8,376)	168,183			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					91,171	91,171		91,171			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,113	30,113		30,113		30,113			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			30,113	30,113	91,171	121,284		121,284			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	865,867	154,047	600,101	1,620,015		1,620,015	28,136	1,648,151			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	142	30		9
10	Interest and Other Investment Income	(155)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(109)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(745)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(4,492)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(302)	20		28
29	Other-Attach Schedule	(6,467)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (12,128)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	40,264		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 40,264		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ 28,136		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X	39,744	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule THERAPY			51,427	10	45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 91,171		47

ID#0035642

Report Period Beginning:01/01/2003

Ending:12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 564	6	1
2	BANK CHARGES	(531)	21	2
3	HEALTHCARE HORIZONS DATA PROCESS	(6,500)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,467)		49



## Summary A

**12/31/2003**

[illegible]

## Summary B

**12/31/2003**

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WILLIAM IRVINE	50	TAMMERLANE HEALTHCARE CTR., INC.				
		CARBONDALE NURSING & REHAB. CTR., INC.				
ROBERT HEDGES	50					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	\$ 892	HI CARE MANAGEMENT		\$	\$(892)	1
2	V	5	UTILITIES				376	376	2
3	V	6	MAINTENANCE				3,709	3,709	3
4	V	7	SCAVENGER				18	18	4
5	V	10	NURSING CONSULTANT				727	727	5
6	V	17	OFFICER SALARIES				16,796	16,796	6
7	V	19	PROFESSIONAL FEES				349	349	7
8	V	20	DUES & SUBSRIPTIONS				89	89	8
9	V	21	CLERICAL				16,697	16,697	9
10	V	23	SEMINARS				41	41	10
11	V	24	TRAVEL				1,590	1,590	11
12	V	26	INSURANCE				549	549	12
13	V	27	PAYROLL TAXES/GROUP INS				8,578	8,578	13
14	Total			\$ 892			\$ 49,519	\$ * 48,627	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 122,012	H & I PROPERTIES		\$	(122,012)	15
16	V	30	DEPRECIATION				25,654	25,654	16
17	V	32	INTEREST				87,995	87,995	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 122,012			\$ 113,649	\$ * (8,363)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.	50.00				SALARY	\$ 8,541	17-8	1
2	TOTAL SALARY RECEIVED FROM HICARE \$72414										2
3											3
4											4
5											5
6	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.	50.00				SALARY	8,255	17-8	6
7	TOTAL SALARY RECEIVED FROM HICARE \$69722										7
8											8
9											9
10											10
11	MARTH IRVINE										11
12	TOTAL SALARY RECEIVED FROM HICARE\$6672								790	21-8	12
13								TOTAL	\$ 17,586		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

**Ending: 2/31/2003**

( 217 )528-3412

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	123,646	6	\$ 3,172	\$	14,639	\$ 376	1
2	6	MAINTENANCE	PER RESIDENT DAY	123,646	6	31,328	30,614	14,639	3,709	2
3	7	SCAVENGER	PER RESIDENT DAY	123,646	6	151		14,639	18	3
4	10	NURSING CONSULTANT	PER RESIDENT DAY	123,646	6	6,137	6,137	14,639	727	4
5	17	OFFICER SALARY	PER RESIDENT DAY	123,646	6	141,866	141,866	14,639	16,796	5
6	19	PROFESSIONAL FEES	PER RESIDENT DAY	123,646	6	2,945		14,639	349	6
7	20	DUES & SUBSRIPTIONS	PER RESIDENT DAY	123,646	6	753		14,639	89	7
8	21	OFFICE EXPENSE	PER RESIDENT DAY	123,646	6	141,028	104,723	14,639	16,697	8
9	23	EDUCATION & SEMINAR	PER RESIDENT DAY	123,646	6	350		14,639	41	9
10	24	TRAVEL & EDUCATION	PER RESIDENT DAY	123,646	6	13,430		14,639	1,590	10
11	26	INSURANCE	PER RESIDENT DAY	123,646	6	4,634		14,639	549	11
12	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	123,646	6	72,452		14,639	8,578	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 418,246	\$ 283,340		\$ 49,519	25



IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	ILLINI BANK		X	POWER LIFTER SCALE	\$140.00	09/01/02	\$ 4,291	\$ 3,270	07/01/06	0.2248	\$ 841	1	
2	NB CHASE		X	AUTO LOAN	\$648.17	02/28/02	27,044	16,161	03/14/06	0.0690	1,358	2	
3	ILLINI BANK		X	DEBT CONSOLIDATION	\$495.17	05/10/02	23,776	17,387	05/10/07	0.0914	1,797	3	
4	VARIOUS VENDORS										1,679	4	
5	Related Party-Illini Bank			MORTGAGE	\$9,238.00	6/11/02	1,160,130	1,121,264	5/30/05	0.0725	84,645	5	
	Working Capital												
6	ILLINI BANK		X	LINE OF CREDIT	INTEREST	REVOLV	26,000	221,987	REVOLV	PRIME +	9,950	6	
7	Rel.Party-Illini Bank		X	WORKING CAPITAL	\$1,838.00		91,000	89,332	REVOLV		3,350	7	
8												8	
9	TOTAL Facility Related				\$12,359.34		\$ 1,332,241	\$ 1,469,401			\$ 103,620	9	
	B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES								10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,332,241	\$ 1,469,401			\$ 103,620	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)



IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																						
1. Real Estate Tax accrual used on 2002 report.				\$	14,6711																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	14,8342																			
3. Under or (over) accrual (line 2 minus line 1).				\$	1633																			
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	14,8344																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$	5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>				\$	6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	14,9977																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:		1998	13,842	8	<table><tr><td colspan="3">FOR OHF USE ONLY</td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2002</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>	FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2002	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR OHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2002	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
		1999	13,348	9																				
		2000	14,206	10																				
		2001	14,671	11																				
		2002	14,834	12																				
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL																								
THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.																								

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

NEW BEGINNINGS CARE CENTRE

COUNTY

WHITESIDE

FACILITY IDPH LICENSE NUMBER

0035642

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE ( 847 ) 675-3585

FAX #: ( 847 ) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	11-27-401-002	NURSING HOME	\$ 14,833.86	\$ 14,833.86
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 14,833.86	\$ 14,833.86

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

Frame

Number of Stories

1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	67,000	1998	\$ 83,295	1
2					2
3	TOTALS	67,000		\$ 83,295	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	55		1998		\$ 698,118	\$ 17,900	39	\$ 17,900	\$	\$ 96,232	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PARKING LOT IMPROVEMENTS			1992	17,677	561	31.5	561		6,446	9
10	CURTAIN TRACKS			1993	5,650	179	31.5	179		1,962	10
11	REWIRING WORK			1996	6,043	155	39	155		1,182	11
12	ROOF			1997	66,564	1,707	39	1,707		10,740	12
13	OUTDOOR FLOODLIGHTS			1997	2,856	73	39	73		441	13
14	HANDRAILS& WALL GUARDS			1999	2,524	65	39	65		295	14
15	STORAGE BARN			1999	2,100	54	39	54		245	15
16	BACKFLOW PREVENTER			2000	1,696	62	27.5	62		219	16
17	ROOF			2000	2,680	97	27.5	97		344	17
18	NEW WATER HEATER			2001	3,096	113	27.5	113		287	18
19	ALARM SYSTEM			2001	5,013	182	27.5	182		463	19
20	OVERBED LIGHT			2001	3,687	134	27.5	134		341	20
21	CARPET			2001	1,730	332	5	346	14	1,038	21
22	WATER HEATER TANK			2002	1,678	61	27.5	61		94	22
23	ALARM SYSTEM			2002	4,991	182	27.5	182		281	23
24	WATER HEATER			2003	2,846	56	27.5	56		56	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$828,949	\$21,913		\$21,927	\$14	\$120,666	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$56,323	\$7,248	\$5,632	\$(1,616)	10	\$23,206	71
72	Current Year Purchases	3,316	1,825	166	(1,659)	10	166	72
73	Fully Depreciated Assets	21,095					21,095	73
74	RELATED PARTY	77,542	7,754	7,754		10	42,647	74
75	TOTALS	\$158,276	\$16,827	\$13,552	\$(3,275)		\$87,114	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		95 BUICK CENTRY	2000	\$6,181	\$	\$	\$	3	\$6,081
77		2000 CADILLAC DEVILLE	2002	27,044	5,612	9,015	3,403	3	13,523
78									
79									
80	TOTALS			\$33,225	\$5,612	\$9,015	\$3,403		\$19,604

E. Summary of Care-Related Assets					1	2
		Reference				Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	1,103,745
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	44,352
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	44,494
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	142
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	227,384

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease
- 

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$5,227
- Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	\$
13.	/2005	\$
14.	/2006	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.



XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			51,427			51,427	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				39,744		39,744	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 51,427	\$ 39,744		\$ 91,171	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 13,480	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	340,404		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,737		6
7	Other Prepaid Expenses	1,500		7
8	Accounts Receivable (owners or related parties)	48,844		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 448,965	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	129,101		15
16	Equipment, at Historical Cost	122,264		16
17	Accumulated Depreciation (book methods)	(112,074)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 139,291	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 588,256	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 307,722	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	265,676		29
30	Accrued Salaries Payable	32,040		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,193		31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,834		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 635,465	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	720,327		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 720,327	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,355,792	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (767,536)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 588,256	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (690,029)	1
2	Restatements (describe):		2
3	ROUNDING	5	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (690,024)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(77,512)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (77,512)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (767,536)	24 *

\* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,532,154	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,532,154	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	10,194	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 10,194	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	155	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 155	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,542,503	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	346,733	31
32	Health Care	744,259	32
33	General Administration	322,351	33
	B. Capital Expense		
34	Ownership	176,559	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	30,113	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,620,015	40
41	Income before Income Taxes (line 30 minus line 40)**	(77,512)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (77,512)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.  
TAX RETURN PREPARED ON CASH BASIS

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,954	2,146	\$ 48,033	\$ 22.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,480	4,703	107,701	22.90	3
4	Licensed Practical Nurses	4,760	5,185	91,872	17.72	4
5	Nurse Aides & Orderlies	29,294	31,963	280,636	8.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,792	2,061	19,369	9.40	8
9	Activity Director	1,978	2,211	21,913	9.91	9
10	Activity Assistants	1,964	2,246	14,376	6.40	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,794	1,996	19,918	9.98	13
14	Head Cook	5,032	5,626	37,187	6.61	14
15	Cook Helpers/Assistants	5,491	6,387	46,946	7.35	15
16	Dishwashers					16
17	Maintenance Workers	1,890	2,163	21,930	10.14	17
18	Housekeepers	5,301	5,827	33,449	5.74	18
19	Laundry	4,668	5,068	28,940	5.71	19
20	Administrator	1,912	2,080	50,286	24.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,850	2,284	20,922	9.16	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care plan supervisor	758	832	13,238	15.91	32
33	Other(specify) CHAPLAIN	898	949	9,151	9.64	33
34	TOTAL (lines 1 - 33)	75,816	83,727	\$ 865,867 *	\$ 10.34	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 4,081	1-3	35
36	Medical Director	O	3,850	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	600	10-3	39
40	Physical Therapy Consultant	L	1,661	10a-3	40
41	Occupational Therapy Consultant	Y	1,450	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	1,690	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 13,332		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	439	18,413	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	439	\$ 18,413		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
CHRISTINE HAMILTON	ADMIN		\$ 50,286	Workers' Compensation Insurance		\$ 28,256	IDPH License Fee	\$
	ASST ADMIN		0	Unemployment Compensation Insurance		17,621	Advertising: Employee Recruitment	1,100
				FICA Taxes		66,239	Health Care Worker Background Check	862
				Employee Health Insurance		10,113	(Indicate # of checks performed )	
				Employee Meals		#REF!	MARKETING/ADV/PROMO	4,794
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	0
				EMPLOYEE BENEFITS - OTHER		5,166	LICENSES & PERMITS	604
				EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS	61
				PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOCATION	89
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	0
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	( 0 )
B. Administrative - Other							Non-allowable advertising	(4,492)
Description			Amount	INSURANCE - EXECUTIVE LIFE VI 21		0	Yellow page advertising	(302)
HI CARE MANAGEMENT			\$ 892					
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,		\$ #REF!	TOTAL (agree to Sch. V,	
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								0
							RELATED PARTY TRAVEL	1,590
							Seminar Expense	
							EDUCATION & SEMINARS	747
							Entertainment Expense	( )
SEE ATTACHED SCHEDULE			53,625				(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)							TOTAL	\$ 2,337

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINT/DECORATING	07/99	\$ 4,771	3 YR	\$ 1,590	\$ 1,590	\$ 796	\$	\$	\$	\$	\$	\$
2	PAINT/DECORATING	07/00	3,379	3 YR	563	1,126	1,126	564					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 8,150		\$ 2,153	\$ 2,716	\$ 1,922	\$ 564	\$	\$	\$	\$	\$

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 30,113  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees